GENDER AFFIRMATION THERAPY AS ACCOMMODATION: TRANSITIONING IN A NONIDEAL SOCIETY BASED ON AN INFORMED CONSENT MODEL

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Abstract

Trans people who seek out Gender Affirming Therapies have historically met various barriers as they have gone through the process of transitioning. From restrictive diagnoses to unversed medical practitioners to misunderstandings of what transness is; general medical practice has created a strict gatekeeping model that creates a difficult environment for trans people.

Many of these barriers are based in the pathologization of trans identities through the Gender Dysphoria diagnosis — though a reality for many trans people, the exclusivity and subjectivity of this diagnosis can cause extensive problems for trans people who seek Gender Affirming Therapies but do not experience Gender Dysphoria, or do not experience it "correctly". However, if the paradigm were to shift towards a theory of transness as an atypicality that is problematized by the standards of our current society, the medical community could begin to see its role in accommodating and advocating for transition services while deferring to a trans person's autonomy in seeking these services.

From this, the informed consent model appears as the best possible way for trans people to receive medically-assisted transition services without the restrictions put in place by psychiatrists and physicians. Though some may object to this model or theory based on the discrete aspects of transitioning, the gestalt of the trans identity and the ultimate goals associated with medically-assisted transition provide a counterpoint to many of these objections.

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Disclosure

The author of this thesis is a cisgender man.

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Introduction

Trans identities have existed in cultures around the world for centuries. As medicine has advanced, the medical community has developed methods to more readily affirm an individual's gender beyond just socialization. However, these new methods rely on a basis of pathologizing gender as a means of securing trans people therapies necessary for their medical affirmation (often times due to restrictions placed by health insurance providers). Though not all trans people require or even desire medical intervention in order to affirm their gender, many still do and providing access to those medical interventions as part of a holistic approach to respect for the autonomy of trans individuals is key to establishing justice for the trans community. For those who desire it, Gender Affirmation Therapies (GAT), including Hormone Replacement Therapy (HRT) and gender affirming surgeries, have been shown to improve health outcomes for trans people and reduce instances of suicidality (Hughto et al.). This is not to say that a trans person who seeks out GAT is in any way more "legitimate" of a trans person than one who does not seek it; but, as the focus of this paper is on therapies meant to affirm the gender of trans people who pursue them, they will be the group most often referenced in this paper.

I will here argue that, in the interest of protecting trans people and establishing respect for the community, a model of informed consent in order to obtain HRT should be the standard of care for those who need it. In order to do this, the medical community must reframe GAT not as a cure for the mental distress of Gender Dysphoria but rather as an accommodation for certain trans individuals to better flourish in a nonideal society.

Trans identities cover any individual whose gender does not concur with the gender they were assigned at birth. This could include individuals that are of the opposite end of the gender

binary than what they were assigned at birth (e.g., a trans woman assigned male at birth) or individuals that do not fall on the gender binary (referred to as “non-binary,” or “enby”). Non-binary individuals may not fit into the general gender paradigm, but they have an historical presence in various cultures around the world. Further gender minorities such as genderfluid, genderqueer, and agender identities may have similar circumstances as trans identities (and may even be covered under the adjective of ‘trans’). The individual experiences and drives of any person falling within these identities may lead them to pursue varying levels of GAT (socialization, HRT, or gender affirming surgery) or none of them depending on how they represent themselves. Some trans individuals may desire a certain level of GAT but be unable to access it for various contextual reasons of their own experiences or due to structural oppression built into society.

The informed consent model for GAT in this paper will be outlined through three distinct claims: (1) The current pathologization of trans identities is unsatisfactory and restrictive and, instead, trans identities should be viewed as an atypicality that is problematized by a nonideal society; (2) GAT serves as an accommodation to improve the lives of trans people who seek it to better flourish in a nonideal society; and (3) An informed consent model for administering GAT is the best option for accommodating trans people based on their lived experiences and the role of medical practitioners in GAT.

The Mere-Difference Principle

Gender Dysphoria is a relatively new concept first suggested in 1973 and fully outlined in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) in 2013. The DSM-5 provides 6 specific criteria for diagnosing Gender Dysphoria in adults (8 for children) requiring at least 2 be present in a patient (6 for children) and also requiring that these criteria result in

"clinically significant distress or impairment in…important areas of functioning" (same for children) (Zucker). These criteria include discordance between one's morphology and lived experiences within their gender, desire to change one's secondary sexual characteristics, and a strong belief and wish to be treated as the gender they were not assigned at birth. This iteration (as opposed to transsexualism and Gender Identity Disorder which were previously used to diagnose trans people and were coupled with paraphilic disorders in earlier editions of the DSM) is noted in that it distinctly removes gender identity itself as a mental health disorder and yet still describes gender identity as a mental disorder when it is discordant with the gender assigned at birth. Along with the criteria being exclusive to the experiences of some, the requirement for "clinically significant distress" and how that is measured and evaluated by the diagnosing physician go further to restrict proper medical identification of trans people. Along with the DSM-5, there are other manuals that outline diagnoses and methodologies for administering transition services such as the World Professional Association for Transgender Health (WPATH) Standards of Care and the International Classification of Diseases, tenth edition (ICD-10) — this paper will focus on the DSM-5 diagnostic model as it is the prevailing manual for diagnosis in the United States.

Let us consider the usage of Gender Dysphoria as the primary means of medically assessing trans identities. Though it is true that many trans people pre-transition do experience Gender Dysphoria, the diagnosis and criteria as laid out in the DSM-5 are considered by many to be restrictive and non-descriptive of many trans people who seek medically accommodated gender affirmation. The diagnostic criteria can be read as subjective and specific, restricting access to GAT due to the interpretation of mental health practitioners who are providing

diagnosis and recommendations to the prescribing medical practitioner. One primary goal as laid out in this paper and within an accommodation-based paradigm is to move past the diagnosis of Gender Dysphoria as a defining medical characteristic of trans people. Many trans people who seek medically accommodated gender affirmation do not experience Gender Dysphoria, and others experience it during or after they transition. The diagnostic model attempting to medicalize gender will inevitably exclude some who seek medically accommodated gender affirmation. Thus, an attempt to address Gender Dysphoria as a difference within a trans person would seem to imply that Gender Dysphoria exists alongside one's trans identity as opposed to distress caused by the internalized or externalized social conception of cisgender norms — a trans person may experience Gender Dysphoria, but it is not prescriptive of being trans and thus should not be used as the diagnostic tool for prescribing GAT. Moving forward, the notion of Gender Dysphoria should be taken as one symptom to be addressed by accommodation, but that the accommodation model is not inherently built to address it — accommodation allows a trans individual who seeks it to more readily flourish in the nonideal society. For a concept of accommodation instead of treatment, the Mere-Difference Principle for disability provides a strong analogue.

In her book *The Minority Body*, Dr. Elizabeth Barnes outlines the Mere-Difference Principle about disability: Reduced down to its key idea, the Mere-Difference Principle dictates disability as a condition that, in an idealized society, would not require intervention in order to improve the life and well-being of the person with the disability. In her work, she speaks only about physical disabilities, leaving mental and cognitive disabilities aside for the time being. One may extrapolate her idea of an "idealized society" as outlined in this principle — one that is

completely accessible for people of all abilities. In this idealized society, a person labeled as "disabled" to us would bear a mere difference, an atypicality in which that person's ability to flourish and achieve well-being is primarily hindered by the nonideal society in which the disabled person exists, rather than a "bad difference," which causes negative outcomes for the individual primarily due to the nature of the difference itself as opposed to the social constructs in which the difference is experienced (Barnes). However, that is not to say that the disability does not exist or is a mere social construct — there is an atypicality of the body that differs from the presiding morphological presentation of bodies in society. Dr. Barnes goes on to note that, as we do not exist in an idealized society in which persons with varying abilities may flourish in the same way, accommodation should be made in order to closer approximate that idealized society for disabled individuals (Barnes). This accommodation is already laid out in modern legislative policy most clearly indicated in the American Disabilities Act (Society for Human Resource Management). Though this may pertain specifically to employers, these accommodations allow for disabled people to more readily participate (and thus flourish) in a society that historically has been difficult to access. In this way, we may begin to think about what an idealized society would look like for a trans person.

Gender is an integral part in shaping most if not all societies. The cisgender, heterosexual nuclear family stands as the base unit for community and society in many cultures around the world based in the reproductive capabilities of the family. In this way, those societies may grow and expand, providing more members to further grow and reproduce and so on. While an idealized society in which people with disabilities are empowered to flourish and develop along with their non-disabled comrades seems not unreasonable, one in which a trans person may

flourish in the same way might seem more nebulous. Even in that idealized society (perhaps one where GAT is readily and easily available), a person's morphology may not always line up with their gender (as this society would still have a strict correlation between morphology and gender) and they may wish to have their body reflect the gender that they are, and any distress derived from that difference would still fall under the definition of Gender Dysphoria. This would then be considered what Dr. Barnes refers to as a bad difference, as even in that idealized society, removing the Gender Dysphoria would notably improve the lives of trans people.

However, with the concept of an "idealized society," perhaps one only needs to expand their consideration of what that ideal would be. Let's imagine one where gender is completely divorced from morphology, one in which children are not assigned a gender at birth and are provided the space and structure in which to define their own gender and presentation as they grow into their identity. One may consider whether an individual provided with the blank slate of themselves and empowered to experiment and describe their own identity as they grow would eliminate Gender Dysphoria as a condition when, inevitably, morphological presentation is not necessarily associated with gender. Whether this idealized society would in fact provide the space in which a trans person would not experience dysphoria is unclear; what is clear, however, is that societal structures and tacit acceptance of gender as based on strict morphological standards indicate transness as not a bad-difference in an individual who does not fit those standards, but rather a mere-difference penalized by society as it currently stands.

In her work, Dr. Barnes identifies the realities of modern society for disabled people — one in which searching for a 'cure' for disability is seen as a noble task due to the deplorable conditions of living with disability (even for those who are profiled as flourishing "in spite of"

their disability) (Barnes). This perceived bad-difference of disability is only bad due to the society in which it exists, but indeed it exists in that society. Thus, advocacy for understanding life with disability, funding access to accommodation for improvement of day-to-day life for disabled people, and other immediate results that attend to the needs of the disabled today must be examined and promoted; in this same way we can examine the needs of trans people who seek out GAT. Though an idealized society in which gender is not a structural pillar may alter the needs of trans individuals, the burden of "degenderizing" society should not fall on trans people; alleviating society of that burden at some indeterminate time in the future will also not attend to the needs and well-being of trans individuals today. In this way, though we may be able to philosophize on that idealized society, it is imperative to focus on the immediate processes that can accommodate for the shortcomings of a non-ideal society.

HRT as Accommodation

As stated before, trans identities themselves are not a pathology and thus do not require a diagnosis. Gender Dysphoria is meant to pathologize trans identities in order to create a medical niche that would establish grounds under which to provide treatment. Medical practitioners should pathologize actual pathologies and provide treatment in remedying them — chemotherapy for cancer, antivirals for HIV, and amputation for gangrene. In the case of trans identities, as they are not pathologies, the medical community has attempted to define them by mental health signifiers that most commonly occur in trans people. However, in this way, the medical community has restricted the definition of trans identities in a way that is not indicative of all trans experiences. Some may not experience Gender Dysphoria, but will experience Gender Euphoria (or the joy and pleasure of presenting and socializing as their gender) (Benestad). In

other cases, trans people who have medically transitioned will still experience Gender Dysphoria, indicating its lack of absolute adherence to a trans person's state of transition (Becker et al.). Gender Dysphoria stands in this case as an artifact of the social structure and the perception of gender within that structure as opposed to an inherent trait in trans identities. This can be compared to the role that the same social structure serves to impair the flourishing of disabled people — it is within the social structure as opposed to that of the atypicality of the body that creates the problems. Thus, labeling GAT as accommodation within that nonideal social structure follows Dr. Barnes's logic in accommodation for physically disabled people for that same social structure.

HRT provides accommodation to trans people who need it to flourish in a society where binary gender is the presiding paradigm. Even for non-binary gender identities, HRT can provide accommodation away from an incorrect morphology into the presentation, performativity, and perception of their actual gender — though this may not align with the idea of accommodation as presented for binary trans people, its goal is still the flourishing of the individual away from the traditional social construction of their assigned gender at birth, whether it allows them to adhere more closely to the paradigm established within society or not. The sense of accommodation derives from a trans person's autonomous decisions of their presentation, performativity, and perception beyond what society initially ascribed them at birth and in their youth, prior to the structuring of the individual's autonomy. That is to say: just as accommodation for physically disabled people does not completely erase their disability or remove the existence of physical impairments, so too does GAT adjust the circumstances of an individual within the nonideal society as the individual feels is best for them.

GAT as accommodation goes beyond the abstract conception of gender as a social construct, performativity, or identity, manifesting as an empirical benefit to the lives of trans people. GAT, whether through socializing or medical processes, has shown in research to be associated with improvements in mental health for trans individuals (Hughto et al.). This includes drops in depression, anxiety, and suicidality. As the different forms of GAT are often considered an upward tiered approach (socialization to HRT to gender affirming surgeries, with the most trans people practicing socialization and numbers decreasing as we move upward through the tiers), it is often difficult to assess the levels of compounding good each successive step provides, but the overall positive outcomes in mental health for each tier is reason enough to consider each tier of GAT as steps towards flourishing for trans people.

Research has shown that, when GAT-seeking trans people are unable to access HRT, they will sometimes pursue treatments outside the medical system. This self-mediated HRT includes anecdotal information found on forums, documents and scientific studies online, and word-of-mouth recommendations passed along through the trans community. Without the advice and check-ups performed by medical practitioners, trans people can administer incorrect dosages of HRT, use unsafe needles and other paraphernalia, and miss health-risk indicators that a medical practitioner may catch. Trans people may also not be aware of crucial information that a medical practitioner can share with them such as the viability of reproduction during and after transition or physiological and emotional changes that may occur. In these cases, HRT is often purchased online from potentially disreputable vendors that may not be supplying what they say they are, exposing trans individuals to further danger or undesirable results (Metastasio et al.).

Expanding access to HRT into an informed consent model in this instance can be seen as a means of harm reduction, in part due to cases where the current diagnostic model has failed trans individuals. If the individual fails to meet the criteria for Gender Dysphoria, is unable to access a doctor or psychiatrist who feels comfortable in the diagnostic process, or has experienced discrimination or stigmatization from medical professionals, the patient may find other means of seeking out treatment that can be dangerous or unsuccessful. An informed consent model for accommodation may not address the latter two problems immediately, but it may empower a physician to trust their patient to make the decisions necessary as opposed to feeling a paternalistic need to contradict or question the patient's need for HRT. These latter two problems also reflect the reports from trans individuals on the lack of sufficient education in trans health matters (Safer et al.). Reducing the barriers to HRT access while empowering patients to direct their GAT as accommodation may ease some of the discomfort that medical practitioners feel when they believe it is their responsibility to permit or refuse certain treatments for their patients. Gender Dysphoria and discrimination by clinicians are not universal to trans people nor indicative of the trans identity, but rather of the nonideal society in which trans people exist. An accommodation model would improve the experience of trans people, providing support and expertise where necessary while still promoting the individual as the primary leader in their transition. It is important to note, however, that the harm that is being reduced in these instances derive from the nonideal society — lack of access to GAT, discrimination from medical practitioners, and even Gender Dysphoria can all be linked to the nonideal social construct in which they live. That is not to say, however, that any of these harms are prescriptive of the trans experience.

The importance of GAT (specifically HRT) as accommodation and not treatment for a pathology is the medical practitioner's role in administering dosage and monitoring for negative side effects. Adhering to a medicalized "cure for Gender Dysphoria" not only problematizes the concept of trans identities as creating mental distress in the current society, it also provides too narrow a lens through which access to GAT may be assessed. Instead, as accommodation, we shift the role of the medical practitioner away from one who gatekeeps through diagnosis, but rather assesses the patient's understanding and informed consent for GAT and monitors for negative outcomes that may derive from GAT. This is not a new role for medical practitioners: Monitoring conditions and addressing negative outcomes as they occur as opposed to prohibiting certain activities or choices as a means to prevent potential (and often rare) medical complications is one they are well-suited for.

Within the disability spectrum, we see the medical community serving as a means to not only provide disabled individuals with accommodation, but to evaluate its effectiveness and possible negative consequences. Clinicians may observe individuals with amputated limbs and provide new prosthetics as the individual grows and changes. Hearing aids are checked and adjusted for the benefit of deaf people who need them, especially cochlear implants which are medically implanted under the skin by a clinician. Due to the lifelong disability that many face, it is the medical community's responsibility to assure that those accommodations grow and change with the disabled person so that the role of accommodation may be maintained. In this same way, a clinician may monitor a trans person's transition and assure the efficacy of the process while monitoring for any possible negative outcomes that can arise from that transition. However, in both cases, the clinician should focus on a patient-centered evaluation of their

experience, ensuring that they are able to flourish and develop as they see fit with the assistance of accommodation. If Dr. Barnes's conception of disability as a mere-difference problematized by a nonideal society is correct, then similar arguments for trans people would follow a parallel trajectory with GAT as accommodation in this instance. In this way, there are other examples within a medical context in which a condition may not be a pathology, but would require medical assistance to ensure best possible outcomes.

Disability is not a unique condition in which the medical system serves as the primary source of accommodation and care. Pregnancy in and of itself is not a medical diagnosis nor a disorder. However, millions of births every year are facilitated in medical facilities by healthcare practitioners — these practitioners provide guidance, advice, and support during the pregnancy and often are best suited for facilitating the birth of the child. Barring actual medical complications, healthcare practitioners defer to autonomy and informed consent of their patients in decisions about vaginal birth versus caesarian section, provision of painkillers, and many other aspects of the child birthing process. Pregnancy is not a disease, but it is a health risk (Speidel et al.). With respect to that health risk, the significant role of the healthcare practitioner during their patient's pregnancy and childbirth is to monitor for any complications that can come about and to assure a healthy term and birth. In this same way, we can consider the physician's duty to their trans patient — to observe and respect their choices about their own condition and be on the look-out for potential complications. GAT can have medical complications associated with hormone administration and it is the physician's duty to watch out for them, but in the end the physician's role in GAT should be to observe their patient following their goals in medically affirming their gender as safely as possible (Shatzel et al.).

Another example of medical practitioners primarily respecting the autonomy of their patients until injuries arise is in the world of sports medicine. A standard medical practitioner may make the paternalistic (and rather obvious) observation, “Not playing professional football on a daily or weekly basis will reduce your chances of getting a concussion.” Professional sports have a long and arduous history of injuries to players; however, sports medicine practitioners will most likely not make baseline recommendations to players that they shouldn’t play as there is an increased likelihood they will become concussed. Though the sports medicine practitioner may outline these risks to their players as a means of adhering to their medical ethics, they will also respect their players’ autonomy in deciding to still play. Then, when the player is eventually concussed due to the sport, the sports medicine practitioner will then step in to assess, treat, and provide updated guidance based on the severity or frequency of such accidents. It is in this way that medical practitioners for trans people may provide information as to the risk that GAT can cause to the patient, but then respect their autonomy in moving forward with such therapies addressing medical concerns as they arise.

HRT based on an informed consent model for cis women (that is, non-trans women) experiencing menopause reveals an evident contrast in usage of HRT from trans women. Menopause, much like pregnancy (and trans identities as I have argued), is not a pathology but rather a condition or circumstance in which medical attention can serve as a bulwark against negative outcomes offered by medical accommodation to flourish in life. During menopause, a person’s hormone levels become atypical to that which they had experienced before as the body transitions out of the possibility for reproduction. This can happen naturally later in life or due to

a surgery that disrupts reproductive abilities. This atypicality in hormone levels can lead to physiological responses such as hot flashes, sleep disturbances, and urinary tract infections. Though these responses are not uniform across everyone experiencing menopause, they happen with enough frequency to elicit a medical intervention for improved life (National Heart, Lung, and Blood Institute). The hormones that a prescribing clinician would offer are more or less identical to the hormones in HRT provided to trans women, the only difference being the intended impacts. As is true for both cis and trans people, these hormones bring with them certain risks such as concerns about heart disease, cancer, and stroke. For these reasons, it is imperative that a medical provider alert the patient to these risks and to monitor the person's progression; however, this serves as an accessory to the actual intention which is to improve the patient's quality of life. The argument here may be objected to on the grounds that the patient requesting menopausal HRT is looking to maintain a quality of life that they had prior to the onset of menopause, but there are plenty of examples outside of menopause (and especially in physical disability) where a person requests accommodation as their body's progression naturally changes to a level of atypicality (i.e., a person losing their eyesight or hearing over time until they require a guide dog or hearing aid). This may lead one to assume that a non-congenital atypicality of the body that develops later in life may still be considered a candidate for medically-assisted accommodation.

In the examples above, medical practitioners are best suited to provide information to the patient as it is in the practitioner's wheelhouse of being on the lookout for potential negative medical outcomes, just as it is with trans individuals that a practitioner will be best suited to not only provide dosages for hormones or perform surgeries, but also to monitor for whatever

negative outcomes that may occur as a result of GAT. However, it is also the medical practitioner's role to respect the autonomy of the patient and not gatekeep based in an idea of potential negative medical outcomes that may arise. Furthermore, especially within the United States medical system that often requires prescriptions or physician-mandated intervention to make such accommodation accessible and affordable (like prescriptions for wheelchairs or hearing aids), a medical practitioner providing a prescription for GAT as accommodation will increase access to GAT (in some cases where they are impossible to access without) and provide equity to those who are marginalized by the nonideal society.

Current Barriers to HRT Access for Trans People

Currently, there are various sets of guidelines for outlining the medicalization of trans identities and providing GAT as treatment. The most prominent source comes from the DSM-5 that carries the diagnostic criteria for gender dysphoria (Zucker). The evolution of the gender dysphoria diagnosis has moved in a direction away from the pathologization of trans people as well as the discrete separation of trans identities from sexual orientation as well as fetishes involving sexual gratification found through the wearing of clothes of the opposite gender ("transvestism"). Though this evolution is to be evaluated on the basis of growing paradigms within the psychological and psychiatric communities, trans individuals have noted the "dehumanizing" procedure of being reduced to a mental disorder or psychological abnormality in order to receive GAT (Ashley).

In practice, finding an appropriate doctor who will work with a trans individual, obtaining the appropriate diagnosis, and beginning GAT is itself an onerous process that can serve as a barrier to trans individuals affirming their genders. Reports and studies show that the primary

barrier that trans individuals experience in accessing GAT is a lack of familiarity by healthcare providers with GAT and subsequent services necessary (Safer et al.). Further studies indicate an inverse relation of age of the healthcare provider and transphobia, connecting lower rates of transphobia with younger doctors (Shires et al.). In a national survey of trans individuals, 50% reported having to teach their healthcare providers about care for transgender individuals—to note this is of the individuals that were able to find a healthcare provider that they felt comfortable working with and who did not refuse care for the trans person or harass them (Grant et al.). Furthermore, health centers specifically aimed at trans patients as well as medical professionals comfortable and confident in providing GAT to patients are most often found in cities. This issue may be seen as a form of geographical discrimination as trans individuals are not all born in or near urban centers, and thus trans individuals in suburban and rural settings may have a more significant burden in finding appropriate medical care than a trans person living in a major city (Movement Advancement Project). Such barriers set the scene for an arduous journey for trans individuals in getting their hands on HRT to begin medical transition.

Though a doctor may be comfortable providing GAT services to trans individuals, they may not be comfortable in moving forward alone. Due to the ubiquitous acceptance of DSM-5 diagnosis criteria, many physicians will request an evaluation and referral by a psychiatrist or other mental health worker indicating a diagnosis of Gender Dysphoria. In the national survey, half of respondents received a Gender Dysphoria diagnosis despite its noted effect of pathologizing individuals who are diagnosed (Grant et al.). The necessity of seeking out a separate counselor in order to receive this diagnosis itself presents an added barrier due to previous biases and discrimination that can occur within the medical field while incurring further costs on the

part of the individual and further delaying access to life-saving therapies. This is also assuming that the patient is actually experiencing Gender Dysphoria, which is not a reality for all GAT-seeking trans people and which creates a separate barrier in itself.

Health insurance coverage constitutes a potent barrier to trans individuals pursuing GAT. Respondents to the previously mentioned national survey were less likely to have health insurance coverage than the general public (Grant et al.). Furthermore, with health insurance often being tied to employment in the United States, the lack of job protections preceding *Bostock v. Clayton County* which protected trans people from employment discrimination based on their gender meant that many trans people's health insurance coverage was in danger should their job choose to fire them simply due to their gender identity (National Center for Transgender Equality). For those that did have health insurance coverage, gender affirmation surgeries specifically are often excluded from coverage requiring patients to pay out of pocket (Grant et al.). Until universal healthcare becomes a reality in the United States, trans people (that can even access health insurance) and healthcare providers must weave through the bureaucracies and requirements of health insurance providers in order to remove as significant of a financial burden as possible. In this view, there may have to be discussions balancing the burdens and benefits of some dehumanizing processes in order to realistically obtain GAT.

A final barrier exists in representation and education. The presence and extent of trans health in medical education is sporadic and incomplete, contributing to previous references to the lack of comfort many healthcare providers feel towards administering GAT and general trans health services (Nolan et al.). This may also be compounded by trans health's advent in the realm of professional medicine that may explain the correlation in age of healthcare providers with

acceptance of working with trans people or overall levels of transphobia. Further barriers may reside in the fact that the vast majority of healthcare providers are cisgender with less than 1% of new medical students self-reporting as trans, indicating a lack of shared experiences with their patients or a basic misunderstanding of what it means to be transgender (Association of American Medical Colleges).

When specifically focusing on HRT, there are comparators that show the capability of healthcare providers based on previous knowledge, education, and experience. Women that are in the process of or have already gone through menopause have historically been able to obtain HRT in order to combat some of the worst side effects of menopause. The process for obtaining estrogen and progestin (two of the same hormones used in HRT for trans women) was based on an informed consent model where women would meet with their doctors, discuss their intentions with being prescribed HRT and their goals to be achieved with hormones, further discuss risks and benefits associated with HRT to the point where the health care practitioner felt comfortable that the patient understood the risks associated with the treatment, outline potential alternative therapies, and eventually prescribe the HRT (McKinney and Thompson). It is to be noted that HRT for menopausal women has lost popularity in the last decade or so due to correlations with increased risk of cancer and cardiovascular health problems in order to maintain a continuity of condition that a menopausal patient had been experiencing (National Heart, Lung, and Blood Institute). Based on the exceptional health outcomes associated with GAT for trans individuals, one would assume that the process for trans individuals to obtain a prescription would be easier. There may be claims from healthcare providers concerning the matter of identity and the impact that hormones may have in shaping or changing that. However,

as requiring all healthcare providers to attend classes on understanding trans identities and health may be difficult to execute, the medical community should instead center the trans individual's experiences and goals when discussing HRT instead of attempting to diagnose and pathologize the patient's gender or identity.

Though common barriers such as discrimination, bias, transphobia, and abuse in the medical system are present and dangerous for trans individuals, the system operating even at its best exists as a barrier to attaining HRT. Moving away from a diagnosis model for prescribing HRT and focusing more on a framework that centers the interests and autonomy of the trans individual would further reduce the systemic obstacles regularly experienced by trans people.

The Informed Consent Model as a Basis for Prescribing HRT

The Callen-Lorde Community Health Center of New York has developed a protocol for the provision of HRT for trans patients. Their philosophy espouses the role of the healthcare practitioner as a partner in health with their patient who guides their own personal healthcare with their clinician providing the details and recommendations necessary to make an informed decision. The goal of this protocol is to provide hormones to the patient by the fourth visit, all of which occur at the same facility and do not require treatment in mental healthcare in order to receive hormones.

The informed consent model of the Callen-Lorde protocol is reminiscent of any informed consent procedure for research or medical procedures. The first visit includes standard data collection processes for personal and family health and histories, blood draws, experience with transgender identity, and overall mental health history and concerns. The clinician also provides packets of information with regard to HRT as well as discussions as to the purpose, goals, and

outcomes of hormone replacement therapy. These discussions can be modified depending on the level of comfort and familiarity new patients have with hormones and their effects. Crucial information to the discussions includes risks and benefits associated with HRT.

Within the first or second appointment, there should be a much more in-depth education and counseling session focused specifically on the realities of HRT, the expectations of the patient, and the patient's understanding of the treatment as a whole. If the patient can establish informed consent at this time, they may give it, or the clinician may arrange follow-up appointments so as to better structure the informed consent. After this point, interactions with the clinician follow standard physical examination to ensure no complications from the hormones as well as continued verification of capacity and final consent prior to arranging the start of HRT. After HRT is begun, appointments are set up periodically to check on vitals, results, and mental health of the patient as they continue through the process — as mentioned earlier, this is to ensure no complications have arisen since beginning HRT and are akin to standard check-ups.

An important aspect of the informed consent model is the fact that the patient can begin HRT as early as the third visit at the same center. This demonstrates not only continuity and stability of care with visiting the same location, but provides a significantly expedited process compared with one that requires diagnosis from a separate psychiatrist. To note, though there may be a general psychiatric exam performed by the clinician, this is not necessarily to ascertain a diagnosis of Gender Dysphoria, but rather an overall assessment of the patient's mindset and to document potential psychological issues that may need to be addressed outside of HRT. This model also permits the patient to see whatever available clinician is on hand as opposed to having to see the same person multiple times, providing flexibility that assists the patient in their own

personal schedule. This is obtained by the standardization of information, signed formal informed consent, and a checklist process that can be stored in a file within the system (Callen-Lorde).

The clinician's job is not to confirm whether the patient is trans, but rather that the patient understands the transition that they are about to undertake and the treatments that will facilitate the transition — this differentiation is crucial in understanding the clinician's role in an informed consent model for HRT. This specific difference is important for clinicians who may not normally be accustomed to working with trans individuals — the hormones provided in HRT have been used in other medical cases and should not be new to a clinician, and obtaining informed consent for a procedure or treatment should also be a skill well developed in the clinician's wheelhouse. The lack of experience working with trans individuals would not necessarily preclude a clinician from accommodating a patient through their transition.

One concern that may be brought up about this model would be the idea that "basically anyone could get on HRT" and, to put it bluntly: yes, that's the point. As identified earlier, a diagnosis of Gender Dysphoria is not a reality or does not properly outline the experience for many GAT-seeking trans people; removing that barrier increases access to this accommodation. It is disingenuous to argue that anyone would pursue this as a treatment — GAT is a long-term process that affects you both physiologically and emotionally; it's not an easy process in and of itself and requires time and resources for investment. Someone who goes to such lengths to affirm their gender with various therapies, including hormones, is looking to do just that — affirm their gender. These therapies do not need to be protected at the level that they have been previously (and currently) as it is unlikely that someone would pursue such treatments without reason; the informed consent model is built in order to confirm the reasons that a person is

pursuing such therapies. Moreover, HRT is reversible — this is not a concern about a "permanent change," which would alleviate concerns about a need to "detransition". As a note, concerns about detransitioning from a medical point of view are not exactly a common reality for people who go through the process of affirming their gender. The very few cases of people detransitioning that have been recorded have been attributed more to societal, community, or family pressures to retain the gender they were assigned at birth, or due to a lack of resources to maintain treatment (Turban et al.).

Accommodation Model for Gender Affirming Surgeries

Though this paper for the most part advocates an informed consent model for HRT, there should be considerations on similar models for gender affirming surgeries. Surgical transition, in the tiered scope of GAT, is the rarest, most expensive, and most permanent of the therapies. In that way, it may be that fewer trans people desire it than the other forms of GAT or that it is inaccessible to many. Gender affirming surgeries are a series of surgeries used to not only transition the genitalia of the patient but also to readjust certain secondary sexual characteristics to bring the patient's outward appearance more in line with their gender. These surgeries can cost more than $50,000 for an individual to fully complete the series. Even with health insurance coverage for some of these surgeries, not all are considered "medically necessary" despite some of them being considered more crucial for socially transitioning (like Facial Feminization Surgery) than others (like Genital Reassignment Surgery) (Ashley and Ells). This differentiation in levels of "medical necessity" as determined by health insurance plans that cover gender affirming surgeries causes further barriers to these services.

Other objections to gender affirming surgeries posit the "permanence" of these surgeries causing more concern than HRT. In this sense, the consulting clinician may not be considering the amount of time, effort, and resources the patient has already put into transitioning — surgery is not the first stop in a person's transition. For those who seek them, these surgeries are the logical next step and eventual conclusion to a person's gender affirmation — the patient's demonstration of successively higher-tiered therapies should indicate a commitment and measured autonomous choice that does not fall within the consulting clinician's responsibility to deny. Thus, the consulting clinician should consider rather the level of information that the patient has about the procedures in order to obtain informed consent. Paradoxically, surgeries considered "cosmetic" or non-medically necessary such as Facial Feminization Surgery would default to an informed consent model in the same vein as other cosmetic, non-transitional surgeries: They would be more easily obtained medically, but more difficultly accessed financially.

Though an informed consent model should be seen as a benefit to opening access for these surgeries as accommodation just as was discussed for HRT, the level of demand and extant barriers for gender affirming surgeries are vastly different and delve into topics more fully covered in other works. Suffice it to say that surgeries fall into the class of accommodation in the same way that HRT does — they provide a means for surgery-seeking trans individuals to better flourish in the nonideal society in which they exist.

GAT as Cosmetic Alteration or Accommodation

Various objections to both the reality of trans identities and therapies designed for transition have been raised, including to the duty of insurance providers in covering those

therapies. Some of those objections genuinely question the role that GAT has for trans individuals and potential analogues across the psychiatric spectrum. In addressing these objections below, the responses outline the unique place that trans identities hold in our nonideal society, and how GAT can address a deeper societal issue as opposed to one within trans people.

When broken down into its parts, GAT appears as a medical means of cosmetically altering an individual's appearance into one that is more desired. When compared to people who receive surgeries and procedures for purely cosmetic reasons such as facelifts or breast augmentation, GAT moves into the realm of consumer medicine. Remanding GAT to the realm of cosmetic surgery and consumer medicine stands in stark contrast to the principle of GAT as accommodation for trans people since cosmetic surgery based in preference is not covered by health insurance nor is it the subject for concern about access. Another comparison some can make about the outcome of GAT, especially with regard to gender affirming surgeries such as mastectomies or vaginoplasties, construes GAT as body mutilation symptomatic of drastic psychological disorders like apotemnophilia. The first objection (that of GAT as cosmetic surgery) presents GAT as a matter of personal preference and not a concern of providing equitable access since health insurance does not cover facelifts nor is society concerned about making them accessible to those who want them. The second objection (GAT as body mutilation) presents GAT as the symptom of a significant psychiatric disorder that should be addressed instead of catered to. Though in a vacuum GAT may be comparable to standard cosmetic procedures or an inappropriate reaction to a serious psychiatric disorder, in regarding GAT as accommodation we can begin to differentiate the intention and purpose of these procedures with regard to the

context and social construct in which these individuals pursue and follow through such procedures.

As discussed before, Facial Feminization Surgery, though cosmetic in its current interpretation by the medical community, is a crucial part of transition for trans individuals that seek it out. Even more so than genital surgeries ("bottom surgeries"), presenting the secondary sexual characteristics which immediately leads those around the trans person to innately perceive the individual as their gender reaffirms the person's gender in the sheer fact that more people see an individual's face on a day-to-day basis than their genitals (Ashley and Ells). This is not dissimilar from those that seek cosmetic surgeries in non-gender affirming ways — to be perceived well in the social construct of beauty and age (for sake of argument, medically necessary cosmetic surgeries such as cleft palate surgeries will be excluded from this discussion at the moment). This is also, however, where the arguments diverge.

Cosmetic surgery is often based in desire to become something else — to impact one's identity in a positive way. A person may find their appearance unappealing and wish to have it changed in some way based on social constructions of beauty. However, many of the individual decisions made in cosmetic surgery are not necessarily impactful on one's identity. These are decisions that make the patient happy, but not necessarily reaffirm who they are as people, as "someone with fewer wrinkles" is not really the basis for one's identity. This can be contrasted with a trans person whose identity is protected and promoted by these surgeries — a trans woman will say to a cosmetic surgeon "I am a woman and would like you to help me show that to the world;" while a bariatric surgery patient wouldn't necessarily say to their surgeon "I am a skinny person and would like you to help me show that to the world". In this example, the

bariatric surgery patient is more likely to say “I would like to be skinnier” while the trans woman would not say “I want to be a woman.” A bariatric surgery patient or a facelift surgery patient are seeking enhancement, an improvement to their outward appearance based in a personal measurement of what is “better” in this world. Though that understanding of “better” may be subjective, a trans person is not seeking that enhancement or that pursuit of the “better”. They may be seeking socialization and more accessible inclusion into society and wider acceptance and understanding of their gender, but GAT provides a bulwark to their identity as opposed to a transformational enhancement beyond the parameters of one’s identity.

The cosmetic surgery example also brings to mind the sense of medical necessity. There are plenty of cosmetic surgeries that are medically necessary such as cleft palate repairs or skin grafts for burn patients — as these are seen to be medically necessary, they are often covered by health insurance. As outlined above, the depathologization of trans identities means that the most obvious justification for GAT as medically necessary is no longer available. For cosmetic surgery, the health-related arguments refer more to emotional health — changes to a person’s appearance that makes them happier (Hyman). On the surface, it seems that the same argument could be made for trans people, but the idea of making a trans person “happier” through GAT is as reductive as remanding trans identities to a Gender Dysphoria diagnosis. Instead, the primary purpose of GAT is to reaffirm the identity that an individual already has and accommodating that identity in modern society, with happiness (Gender Euphoria in this context) as a positive and pleasant outcome. In this way, GAT as accommodation factors into the well-being and flourishing of an individual in a more complete and holistic manner than cosmetic surgery does.

The final argument against GAT as accommodation is the focus on what surgeries do. Aside from facial feminization, there are others including bottom surgery and mastectomies that may be viewed as the unnecessary removal of healthy tissue. This can often bring pause to surgeons who may be concerned about the reasons and expected outcomes of those surgeries and raise concern about the "permanence" of them. To note, only around 13% of trans people undergo some form of gender affirming surgery—only 0.6% of the population in the United States (Lane et al.). This number may be impacted due to lack of access or social pressures as discussed elsewhere in this paper; regardless, it is a very small percentage of the populace that is seeking out this level of gender affirmation — many do not seek it for reasons aside from access. Each surgery brings with it its own sources of concern and risk as does any surgery, but they are steps to reaffirm identity and accommodate trans individuals in living in a nonideal society in a manner that they see as a best fit for them.

A comparison would be the psychiatric disorder called apotemnophilia. This rare psychiatric disorder is described as an individual's desire for impairment by either amputation of a healthy limb or disturbance of a motor/sensory process so as to become impaired or disabled. Since the early 1970s various explanations have been given as to why apotemnophiliacs desire such unnecessary surgeries: Originally argued as a fetishization of being an amputee, other examples have been based in a love of asymmetry or a desire to feel "more complete" or a desire to see oneself overcome or excel in spite of an impairment. Overall, however, this is a severely understudied and mysterious disorder that requires further investigation (Sedda and Bottini). As happenstance, Dr. Barnes specifically argues in her work that even if disability is a mere-difference, causing disability is still not permissible in this society for the harm that it may cause

and the significant alteration in continuity of self that is created by such intentional impairment (Barnes).

When considering these surgeries, we must once again consider the intention of the trans person in choosing to undergo these surgeries. At this point of their life, a trans person has been socializing and presenting as their gender most likely with the aid of HRT that has allowed them to socialize as their gender more seamlessly in society. The permanence in gender affirming surgeries in itself is not as significant of a concern as the trans person has already been living openly as their gender for some time and have had time to assess their interest in maintaining (and furthering) their gender, a decision that many trans people choose not to make for their own reasons. In comparison to apotemnophilia, the logic from gender affirming surgery follows much more reasonably. For example, the logic of a vaginoplasty can be said to follow as such: "I am a woman. Women in our society do not have penises, they have vaginas. Thus, as a woman I should have a vagina." This is not necessarily a rebuke of the penis (as it is not simply a penectomy), it is a surgery that provides concordance between the body and the social construct in which it lives.

As many critics of GAT focus more on the amputation of the penis during the vaginoplasty rather than the reconstructive ethos of the procedure, one can begin to see the correlation between GAT and amputation for apotemnophilia. However, Dr. Barnes would refute surgery for apotemnophilia in that, even if it is requested by the patient, causing disability in an individual creates greater risk to suffering and harm in the nonideal society than the patient's original status as non-disabled (Barnes). The reconstructive, accommodation-based philosophy of GAT reduces that risk of suffering and harm in the nonideal society for trans people who seek GAT. The

amputation of the apotemnophiliac's limb causes the need for accommodation instead of being the accommodation to the nonideal society (such as GAT is for trans people). Thus, an argument for surgery as a means of accommodation in the nonideal society for trans people stands, but not for the apotemnophiliac that wishes to de-accommodate themself. Though this is not a discussion on the value of apotemnophilia or whether it is "wrong" to want to amputate a limb, it is important to see the distinction in argument between why one would want gender affirming surgeries versus wanton amputation.

Conclusion

Gender Affirming Therapies are not medications meant to treat a mental disorder; they are accommodations meant to empower trans individuals to better flourish in a nonideal society. The trans and non-binary spectrum of identities run the gamut of presentation, performativity, and perception, and it should be decided by those individuals how best to do that. For those who seek medically accommodated transition, that same level of autonomy ought to be granted to them to flourish in the non-ideal, cisgender, binary society in which they exist. Relegating GAT to a treatment of a pathology reduces trans identities and permits non-trans and binary people to dictate the way people present, perform, and are perceived.

Thus, informed consent models, such as the one developed and practice by the Callen-Lorde Community Health Center, respect the autonomy of trans individuals and allows them to direct their own personal transition, providing medical intervention only when the individual's health, not their identity, is the primary concern. Further expansion in medical education and access to knowledgeable providers can also serve as a benefit to trans individuals, but shifting

the paradigm on what it means to affirm one's gender will allow the individual to retain control over how they will best be suited by medical accommodation.

References

Ashley, Florence. “Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising.” *Journal of Medical Ethics*, vol. 45, no. 7, Institute of Medical Ethics, July 2019, pp. 480–82. *jme.bmj.com*, https://doi.org/10.1136/medethics-2018-105293.

Ashley, Florence, and Carolyn Ells. “In Favor of Covering Ethically Important Cosmetic Surgeries: Facial Feminization Surgery for Transgender People.” *The American Journal of Bioethics*, vol. 18, no. 12, Taylor & Francis, Dec. 2018, pp. 23–25. *Taylor and Francis+NEJM*, https://doi.org/10.1080/15265161.2018.1531162.

Association of American Medical Colleges. *Matriculating Student Questionnaire: 2018 All Schools Summary Report*. Association of American Medical Colleges, Dec. 2018, p. 28, https://www.aamc.org/media/9641/download.

Barnes, Elizabeth. *The Minority Body: A Theory of Disability*. First edition, Oxford University Press, 2016.

Becker, Inga, et al. “A Cross-Sectional Multicenter Study of Multidimensional Body Image in Adolescents and Adults with Gender Dysphoria Before and After Transition-Related Medical Interventions.” *Archives of Sexual Behavior*, vol. 47, no. 8, Nov. 2018, pp. 2335–47. *Springer Link*, https://doi.org/10.1007/s10508-018-1278-4.

Benestad, Esben Esther Pirelli. “From Gender Dysphoria to Gender Euphoria: An Assisted Journey.” *Sexologies*, vol. 19, Oct. 2010, pp. 225–31. *ResearchGate*, https://doi.org/10.1016/j.sexol.2010.09.003.

Callen-Lorde. *Callen-Lorde Protocols for the Provision of Hormone Therapy*. Callen-Lorde, 2018, http://callen-lorde.org/graphics/2018/05/Callen-Lorde-TGNC-Hormone-Therapy-Protocols-2018.pdf.

Grant, Jaime, et al. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. National Center for Transgender Equality and the National Gay and Lesbian Task Force, 2011, p. 228, https://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.

Hughto, Jaclyn M. W., et al. "Social and Medical Gender Affirmation Experiences Are Inversely Associated with Mental Health Problems in a U.S. Non-Probability Sample of Transgender Adults." *Archives of Sexual Behavior*, vol. 49, no. 7, Oct. 2020, pp. 2635–47. *DOI.org (Crossref)*, https://doi.org/10.1007/s10508-020-01655-5.

Hyman, David A. "Aesthetics and Ethics: The Implications of Cosmetic Surgery." *Perspectives in Biology and Medicine*, vol. 33, no. 2, Johns Hopkins University Press, 1990, pp. 190–202. *Project MUSE*, https://doi.org/10.1353/pbm.1990.0003.

Lane, Megan, et al. "Trends in Gender-Affirming Surgery in Insured Patients in the United States." *Plastic and Reconstructive Surgery Global Open*, vol. 6, no. 4, Apr. 2018, p. e1738. *PubMed Central*, https://doi.org/10.1097/GOX.0000000000001738.

McKinney, Karen A., and William Thompson. "A Practical Guide to Prescribing Hormone Replacement Therapy." *Drugs*, vol. 56, no. 1, July 1998, pp. 49–57. *Springer Link*, https://doi.org/10.2165/00003495-199856010-00005.

Metastasio, Antonio, et al. "Transitioning Bodies. The Case of Self-Prescribing Sexual Hormones in Gender Affirmation in Individuals Attending Psychiatric Services." *Brain Sciences*, vol. 8, no. 5, 5, Multidisciplinary Digital Publishing Institute, May 2018, p. 88. *www.mdpi.com*, https://doi.org/10.3390/brainsci8050088.

Movement Advancement Project. *Where We Call Home: Transgender People in Rural America*. Movement Advancement Project, Nov. 2019, https://www.lgbtmap.org/file/Rural-Trans-Report-Nov2019.pdf.

National Center for Transgender Equality. "Know Your Rights: Employment (General)." *National Center for Transgender Equality*, 2020, https://transequality.org/know-your-rights/employment-general.

National Heart, Lung, and Blood Institute. *Facts About Menopausal Hormone Therapy*. U.S. Department of Health and Human Services, June 2005, p. 24.

Nolan, Ian T., et al. "Current State of Transgender Medical Education in the United States and Canada: Update to a Scoping Review." *Journal of Medical Education and Curricular Development*, vol. 7, SAGE Publications Ltd STM, Jan. 2020, p. 2382120520934813. *SAGE Journals*, https://doi.org/10.1177/2382120520934813.

Safer, Joshua D., et al. "Barriers to Health Care for Transgender Individuals." *Current Opinion in Endocrinology, Diabetes, and Obesity*, vol. 23, no. 2, Apr. 2016, pp. 168–71. *PubMed Central*, https://doi.org/10.1097/MED.0000000000000227.

Sedda, Anna, and Gabriella Bottini. "Apotemnophilia, Body Integrity Identity Disorder or Xenomelia? Psychiatric and Neurologic Etiologies Face Each Other." *Neuropsychiatric Disease and Treatment*, vol. 10, July 2014, pp. 1255–65. *PubMed Central*, https://doi.org/10.2147/NDT.S53385.

Shatzel, Joseph J., et al. "Thrombotic Issues in Transgender Medicine: A Review." *American Journal of Hematology*, vol. 92, no. 2, 2017, pp. 204–08. *Wiley Online Library*, https://doi.org/10.1002/ajh.24593.

Shires, Deirdre A., et al. “Primary Care Clinicians’ Willingness to Care for Transgender Patients.” *The Annals of Family Medicine*, vol. 16, no. 6, The Annals of Family Medicine, Nov. 2018, pp. 555–58. *www.annfammed.org*, https://doi.org/10.1370/afm.2298.

Society for Human Resource Management. “ADA/ADAAA Policy.” *SHRM*, 14 June 2018, https://www.shrm.org/resourcesandtools/tools-and-samples/policies/pages/adaadaaapolicy.aspx.

Speidel, J. Joseph, et al. “Pregnancy: Not a Disease but Still a Health Risk.” *Contraception*, vol. 88, no. 4, Oct. 2013, pp. 481–84. *PubMed*, https://doi.org/10.1016/j.contraception.2013.03.012.

Turban, Jack L., et al. “Factors Leading to ‘Detransition’ Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis.” *LGBT Health*, vol. 8, no. 4, Mary Ann Liebert, Inc., publishers, June 2021, pp. 273–80. *liebertpub.com (Atypon)*, https://doi.org/10.1089/lgbt.2020.0437.

Zucker, Kenneth J. “The DSM-5 Diagnostic Criteria for Gender Dysphoria.” *Management of Gender Dysphoria*, edited by Carlo Trombetta et al., Springer Milan, 2015, pp. 33–37. *DOI.org (Crossref)*, https://doi.org/10.1007/978-88-470-5696-1_4.